CALIFORNIA FOOTHILLS MEDICAL ASSOCIATES, INC.
ARNOLD I. ROTH, M.D.
8211 ROCHESTER AVE, #101, RANCHO CUCAMONGA, CA 91730
PHONE: 909-945-2425 FAX: 909-948-6971

PATIENT REGISTRATION INFORMATION

PATIENT FULL NAME		DATE OF BIRTH	SOCIAL SECURITY #
STREET ADDRESS ☐PERMANENT ☐TEMPORARY	CITY AND STATE	ZIP CODE	HOME PHONE #
EMAIL ADDRESS:___________________________________CELL PHONE:______________________		SEX ☐MALE ☐FEMALE	ALTERNATE PHONE # FOR EMERGENCY:
PATIENT EMPLOYER	OCCUPATION (INDICATE IF STUDENT)	HOW LONG EMPLOYED?	BUSINESS PHONE #
EMPLOYER STREET ADDRESS	CITY AND STATE		ZIP CODE
DRUG ALLERGIES	REFERRED BY		
RACE ☐WHITE ☐BLACK ☐ASIAN ☐PACIFIC ISLANDER ☐OTHER: ☐DECLINE TO STATE	ETHNICITY ☐HISPANIC ☐NOT HISPANIC ☐DECLINE TO STATE	PREFERRED LANGUAGE ☐ENGLISH ☐SPANISH ☐OTHER: ☐DECLINE TO STATE	MARITAL STATUS ☐SINGLE ☐MARRIED ☐WIDOWED ☐DIVORCED ☐SEPARATED
SPOUSE'S NAME	NUMBER OF CHILDREN AND AGES		
SPOUSE'S EMPLOYER	OCCUPATION (INDICATE IF STUDENT)	HOW LONG EMPLOYED?	BUSINESS PHONE #
EMPLOYER STREET ADDRESS	CITY AND STATE		ZIP CODE
SPOUSE'S STREET ADDRESS, IF DIVORCED OR SEPARATED	CITY AND STATE	ZIP CODE	PHONE #

PERSON TO NOTIFY IN CASE OF EMERGENCY, NOT LIVING WITH YOU

NAME	ADDRESS	PHONE #

IF THE PATIENT IS A MINOR OR STUDENT

MOTHER'S NAME	STREET ADDRESS, CITY, STATE, AND ZIP CODE		HOME PHONE #
MOTHER'S EMPLOYER	OCCUPATION	DATE OF BIRTH	BUSINESS PHONE #
EMPLOYER STREET ADDRESS	CITY AND STATE		ZIP CODE
FATHER'S NAME	STREET ADDRESS, CITY, STATE, AND ZIP CODE		HOME PHONE #
FATHER'S EMPLOYER	OCCUPATION	DATE OF BIRTH	BUSINESS PHONE #
EMPLOYER STREET ADDRESS	CITY AND STATE		ZIP CODE

AUTHORIZATION TO RELEASE AND ASSIGN BENEFITS

I authorize CFMA to disclose to my insurance company(ies), information from the Practice record relating to the identity, diagnosis, prognosis, or treatment of the patient named below. I understand that the purpose of this disclosure is to facilitate the payment of insurance benefits. I hereby assign CFMA, any hospital, medical and/or surgical benefits that I am entitled to under the terms of my insurance policy(ies).

DATE:______________________SIGNATURE: ____

____ __________________________________

PRINT FULL NAME OF SIGNER **RELATIONSHIP IF NOT PATIENT**

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FINANCIAL POLICY AND AGREEMENT

This is an agreement between California Foothills Medical Associates, Inc. at 8211 Rochester Ave., Ste #101, Rancho Cucamonga, CA 91730 (hereinafter "we", "us", "our")

Patient Name ____(hereinafter "you", "your", "patient")

Address ____

City, State, Zip ____

Phone Number ________________________ Cell phone number____________________
Who in consideration of the services rendered by us and of the mutual promises contained herein, agree as follows:

Agreement to Pay: By signing this agreement, you are agreeing to pay for all services that are received and agreed to be bounded by all of the applicable provisions of this Financial Policy and Agreement. Unless otherwise provided herein, you agree to pay us immediately at the time services are rendered or upon demand.

Insurance: Insurance is a contract between you and your insurance company. We are NOT a party to this contract, in most cases. Normally, we bill your primary insurance company as a courtesy to you. Although we may estimate what your insurance company may pay, it is the insurance company that makes the final determination of your eligibility. You agree to pay any portion of the charges not covered by insurance. If your insurance company requires a referral and/or preauthorization, you are responsible to know this and see that it is obtained prior to treatment. Failure to obtain the referral and/or preauthorization may result in no payment or a lower payment from the insurance company and or a balance due by you. This applies to any companies we may send you to for testing.

Discount Cards: We do not accept "discount cards". If you have no insurance and only have a discount card, you will be charged as a cash patient. Cash prices are based on Medicare's fee schedules and cannot be adjusted below this standard.

Required Payments: Any co-payments required by an insurance company must be paid at the time of service, before seeing the doctor. Because this is an insurance requirement, we cannot bill you for any co-pays. Please remember to bring a form of payment to all your appointments.

HOME HEALTH VISITS:
Please be aware that if you have Home Health services there may be a co-pay applied by your insurance. Please check with your insurance to see if they charge you for a co-pay which we will bill you for if your insurance indicates to do so.

Payment Options if you have Insurance: If you have insurance, you have two payment options. Option One: You choose to pay by cash, or credit card on the day that treatment is rendered. Option Two: We will bill your insurance company for any covered services. You are still required to pay any co-pay or deductible, or some other out of pocket portions due at the time services are rendered payable by cash, or credit card. We will not bill for services that we know require an out of pocket fee from you, it is due at time of service. ***We do not bill third party insurances, e.g. car insurance, workers compensation, or any company that is not your health insurance carrier we accept.***

Payment Options if you have no Insurance: You choose to pay by cash, or credit card on the day that treatment is rendered. We do not bill for cash patients. We will need to reschedule you if you are unable to pay for service on the day of your appointment.

Payments: If for any reason you owe us a balance on your account, then the balance shown on your statement is due and payable immediately when the statement is issued and is past due if not paid within 30 days after the statement date, unless other arrangements are approved by us in writing.

Monthly Statement: If you have a balance on your account, we will send you a monthly statement. It will show separately the previous balance, any new charges to the account, the finance charge, if any, and any payments or credits applied to your account during the month.

Finance Charge: A finance charge will be imposed on each item of your account, which has not been paid within 30 days of the time the item was added to your account. The finance charge will be computed at the rate of 10% per month. The finance charge on your account is computed by applying the periodic rate of 10% to the overdue balance of your account. The overdue balance of your account is calculated by taking the balance owed 30 days ago and then subtracting any payments or credits applied to the account during that time. This finance charge is subject to change without notification.

Charges to your Account: We shall have the absolute right to cancel your privilege to make charges against your account at any time for any reason or for no reason at all, whether or not you have insurance. Future visits would then be paid at the time of service.

Missed Appointment Fee: If you do not show up for an appointment or cancel within less than 24 hours, you will be charged a cancellation fee (currently $35.00, subject to change without notice). If you do not show up for a physical exam or office procedure (which extra time is set aside for) or cancel this type of appointment in less than 24 hours, you will be charged a cancellation fee (currently $100 subject to change without notice). Your cancellation fee must be paid before a new appointment will be scheduled. If you no show or cancel late three appointments in succession or within 12 months, you may be asked for your records to be transferred to another doctor.

Past Due Accounts: If your account becomes past due, we may declare the entire unpaid balance due and payable and we will take the necessary steps to collect this debt. If we refer your account to a collection agency, you agree to pay all of the collection costs that are incurred, including reasonable attorney's fee and costs. Should we choose to forebear from exercising our right to accelerate your account or otherwise take any action, said forbearance shall not constitute a waiver of our rights.

Waiver of Confidentiality: You understand and agree that if this account is submitted to an attorney or collection agency, if we choose to litigate in court or if your past due account is reported to a collection agency, the fact that you received treatment at our office and some or all of your medical information and medical records may become a matter of public record as part of the litigation.

Divorce and Separation: In case of divorce or separation, you and/or any other person who was responsible for the account prior to the divorce or separation shall remain responsible for the account, unless we are otherwise notified in writing prior to rendering the services charged to the account. A parent or guardian who authorizes treatment for a child shall be fully responsible on the account for all such charges incurred even if a Judgment or Dissolution or Separation or other order of the court requires that the other parent pay all or part of the treatment costs. It is not our responsibility to collect from the other parent.

Transferring of Records: You will need to request in writing and pay a reasonable copying fee (currently a minimum of $35.00) if you want to have copies of your records sent to another doctor or healthcare organization. You authorize us to include all relevant information, including your payment history. If you are requesting your records to be transferred from another doctor or organization to us, you authorize us to receive all relevant information, including your payment history.

Definitions: In this agreement the words "you", "your", and "yours" mean the patient. The word "account" means the account that has been established in your name to which charges are made and payments credited. The words "we", "us", and "our" refer to California Foothills Medical Associates, Inc. As used herein the singular includes the plural and the masculine includes the feminine and neuter genders whenever the context so indicates. Nothing shall be implied by the naming or order of the paragraphs herein.

Time of Essence: Time is of the essence of this agreement.

Entire Agreement: This is the entire agreement. No promise or representation of any kind shall be binding on us unless such promise or representation is expressly contained in this agreement or in any subsequent agreement in writing.

Binding on Successors: This agreement shall be binding on all of the signatories hereto, their agents, attorneys, personal representatives, heirs, successors, and assigns.

California Law: This agreement shall be interpreted according to California State Law.

Venue and Jurisdiction: You agree that any action or proceeding brought by us to collect a debt shall be brought to Superior Court of the State of California, County of San Bernardino, and Rancho Cucamonga Courthouse.

Notices: All notices, bills, statements of account, memoranda and correspondence shall be mailed (pre-paid, first class US mail) to us and to you at the addresses set forth above (on page one), or delivered to us and to you in person. You agree to notify us of any change of address within 7 days.

Co-signature: If this or another agreement is signed by another person, both you and that person shall be responsible for all charges against the account until the other person notifies us in writing that they are cancelling this agreement, in which case they will not be responsible for services rendered after our actual receipt of their notice of cancellation.

Effective Immediately: By signing this agreement, you agree to all the terms and conditions contained in this agreement, which shall become effective immediately.

Returned Check: There is a fee (currently $35.00) for any checks returned by your bank. This fee is in addition to the amount of the check that was returned unpaid. This fee is subject to change without notice.

Credit Reporting: We have the option to report your account status to any credit reporting agency, such as all credit bureaus.

I HAVE READ, UNDERSTAND, AND AGREE TO THESE POLICIES:

Patient's signature:____Date:______________________

OR

Patient's representative's signature:____

IF PATIENT IS UNABLE TO SIGN OR UNABLE TO UNDERSTAN D AGREEMENT

____

PRINT NAME OF SIGNER

____________________ ____________________

RELATIONSHIP TO PATIENT DATE SIGNED

CALIFORNIA FOOTHILLS MEDICAL ASSOCIATES, INC.
DR. ARNOLD I. ROTH

MEDICAL ILLNESSES

(Please check if you have or had any of the below)

___ Abnormal Heartbeat Year: ______
___ Allergies Year: ______
___ Anemia Year: ______
___ Arthritis Year: ______
___ Asthma Year: ______
___ Blood Clots Year: ______
___ Bladder Infections Year: ______
___ Cancer Year: ______
___ Chicken Pox Year: ______
___ Colitis Year: ______
___ Colon Polyps Year: ______
___ Depression Year: ______
___ Diabetes Year: ______
___ Emphysema Year: ______
___ Epilepsy (Seizures) Year: ______
___ Gallstones Year: ______
___ Glaucoma Year: _
___ Gout Year: ______
___ Headache/Migraine Year: ______
___ Heart Attack Year: ______
___ Heart Failure Year: ______
___ Heart Murmur Year: ______
___ High Cholesterol Year: ______
___ H.I.V. Year: ______
___ Hypertension Year: ______
___ Kidney Disease Year: ______
___ Kidney Stones Year: ______
___ Pneumonia Year: ______
___ Polio Year: ______
___ Psychiatric Disorder Year: ______
___ Rheumatic Fever Year: ______
___ Scarlett Fever Year: ______
___ S.T.D. Year: ______
___ Stroke Year: ______
___ Thyroid Disease Year: ______
___ Ulcers Year: ______

Other ____ Year ___________

SURGERIES

___ Appendix Year _______
___ Breast Mass Year _______
___ Cancer Year _______
___ Colonoscopy Year _______
___ Hysterectomy Year _______
___ Gall Bladder Year _______
___ Heart Year _______
___ Hip Year _______
___ Knee Year _______
___ Spine Year _______
___ Tonsils Year _______
___Kidney Year ______

Other ____ Year ___________

CALIFORNIA FOOTHILLS MEDICAL ASSOCIATES, INC.
DR. ARNOLD I. ROTH

MEDICATIONS

MEDICATION ALLERGIES-STATE DATE OF FIRST OCCURENCE IF KNOWN

Medications	Type of reaction	Date of first occurrence
1) ______________________________	______________________________	
2) ______________________________	______________________________	
3) ______________________________	______________________________	
4) ______________________________	______________________________	
5) ______________________________	______________________________	
6) ______________________________	______________________________	

CURRENT MEDICATIONS (Include strength, how often taken & over the counter, vitamins herbs)

1) _________________________	6) _________________________
2) _________________________	7) _________________________
3) _________________________	8) _________________________
4) _________________________	9) _________________________
5) _________________________	10) _________________________

IMMUNIZATIONS

___ Flu Year _______
___ Hepatitis A Date _______1 Date________2
___ Hepatitis B Date _______1 Date________2 Date_________3
___ Shingles Year _______
___ TDAP Year _______
___ Tetanus Year _______

___ Pneumovax-Pneumonia 23 Year _______ Booster (5 yrs) Year____________
___Prevnar-Pneumonia 13 Year_______

Other ____ Year _____________
Other ____ Year ____________

CALIFORNIA FOOTHILLS MEDICAL ASSOCIATES, INC.
DR. ARNOLD I. ROTH

FAMILY HISTORY

	Living	Deceased	Age	Medical Problems & Cause of Death If cancer, state what type please
Mother	______	______	______	______________________________
Father	______	______	______	______________________________
Brothers	______	______	______	______________________________
	______	______	______	______________________________
	______	______	______	______________________________
Sisters	______	______	______	______________________________
	______	______	______	______________________________
	______	______	______	______________________________
Grandparents	______	______	_______	______________________________
Additional	______	______	______	______________________________
Additional	______	______	______	______________________________

CALIFORNIA FOOTHILLS MEDICAL ASSOCIATES, INC.
DR. ARNOLD I. ROTH

REVIEW OF SYMPTOMS

Do you presently have any of these conditions or have a history of any of the follow?
If so, please check the appropriate items.

Have	Had	
___	___	Allergies
___	___	Anxiety
___	___	Asthma
___	___	Blood in urine
___	___	Bruising
___	___	Chest pain
___	___	Concussion
___	___	coughing up blood
___	___	Depression
___	___	Excessive/ constant worrying
___	___	Feeling lonely/depressed
___	___	Fever/chills
___	___	Frequent/painful urination
___	___	Glaucoma
___	___	Hearing problems/earaches
___	___	Hoarseness
___	___	Impotence/other sexual difficulty
___	___	Inability to sleep well
___	___	Joint swelling/stiffness/pain
___	___	Leg swelling
___	___	Lightheadedness
___	___	Loss of appetite

Have	Had	
___	___	Lumps/growths
___	___	Morning stiffness
___	___	Night sweats
___	___	Painful/difficult swallowing
___	___	Pain while walking
___	___	Persistent abdominal pain
___	___	Persistent back pain
___	___	Persistent cough
___	___	Persistent diarrhea/constipation
___	___	Persistent headaches
___	___	Persistent nausea/vomiting
___	___	Persistent weakness/fatigue
___	___	Rapid weight change
___	___	Rectal bleeding
___	___	Shortness of breath
___	___	Sinuses
___	___	Skin rash/discoloration
___	___	Sores in mouth
___	___	Stomach pain
___	___	Vomiting blood
___	___	Vision problems
___	___	Wheezing

Other ____

Other:____

Other:____

CALIFORNIA FOOTHILLS MEDICAL ASSOCIATES, INC.
DR. ARNOLD I. ROTH

SOCIAL HISTORY

Present Occupation ______________________ Past Occupation ___________________

Have you ever worked with asbestos, oil-derived chemicals, radioactive, or other hazardous materials? ___ Yes ___ No If yes please complete the following:

Location:____ Date:_________________

Location:____ Date:_________________

Location:____ Date:_________________

Cigarette/cigar usage:

___ Current Every Day Smoker

How many packs a day?______

___ Current Some Days Smoker

How many packs a day?______

How many days a week?_________

___ Former Smoker

How many packs a day?______

Quit date?_________________

___ Never Smoked

Do you use street drugs?________

Type of drug?_________________

Intravenous?__________________

Amt/daily?____________________
Alcohol use:
Type:________________________

Number of beer a day____
Number of hard liquor a day _________

Does it interfere with work or family life?
___ Yes ___ No

Do you exercise at least 3 times per week? ___ Yes ___ No

Do you travel for work more than 3 hours per day? ___ Yes ___ No

Are you happy with your home life?
___ Yes ___ No

California Foothills Medical Associates
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8211 Rochester Avenue, Suite 101
Rancho Cucamonga, CA 91730
909-945-2425 fax 909-948-6971

Privacy Officer – Nora Dyer

I hereby acknowledge that I understand that my medical records, written or verbal will not be share either with anyone other than those mentioned in this form unless I give written permission for the release of records, and approve what records that can be shared.

Print Patient Name: ______________________________________DOB:________________

Signature: ____ Date: ______________

Print name of signer if not patient:____

If not signed by the patient, please indicate relationship:

_______ Parent or guardian of minor

_______ Guardian or conservator of an incompetent patient.

_______ Other____

_______ Power of Attorney? If yes please bring copy of order to first visit.

I hereby authorize the office of Dr. Arnold I. Roth to release any information on my medical condition(s) to the following list, in written or verbal form to assist in my care with no further consent necessary from me:

Any pharmacy I designated to fill my medicine prescriptions ______________________INITIALS

Any medical doctor that is involved in my care__________________________________INITIALS

Any Hospital or Imaging Facility that I have testing of any kind with_________________INITIALS

Any laboratory that is designated to do testing for me_____________________________INITIALS

Any Physical Therapy group designated to treat me _______________________________INITIALS

Any company affiliated with my insurance supplying medical equipment _____________INITIALS

My health insurance carrier & their designates _________________________________INITIALS

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PERMISSION TO RELEASE MEDICAL INFORMATION

PATIENT:____DOB:____________________

SS #____OR D/L:_________________________________

I hereby give my consent for Dr. Arnold Roth and staff to release any of my personal medical information to the following person(s), except for any exceptions noted below. I further authorize this information to be release verbally or in written form as requested by the authorized person(s)

Person authorized:____ DOB:____________________
PLEASE PRINT

Person authorized:____ DOB:____________________
PLEASE PRINT

Person authorized:____ DOB:____________________
PLEASE PRINT

****EXCEPTIONS OF MEDICAL INFORMATION NOT TO BE DISCLOSED?**

____

____

____

*****IF NO EXCEPTIONS SIGN HERE INDICATING NO EXCEPTIONS-MAY DISCLOSE ANY MEDICAL INFORMATION**

Signature____

I understand that I may cancel this authorization at any time in written form only to Dr. Roth and staff and must identifying myself with my social security number, my driver's license number and my date of birth. This authorization stands as is until such time as I decide to cancel or change it.

____ ____________________
PATIENT'S SIGNATURE **DATE**

____ ____________________
WITNESSED BY ID-SIGNATURE OF OFFICE STAFF MEMBER-PRINT NAME & INITIAL Date

CALIFORNIA FOOTHILLS MEDICAL ASSOCIATES, INC.

ARNOLD I. ROTH, M.D.

REQUEST FOR MEDICAL RECORDS

DATE:______________________ PATIENT NAME:____

DATE OF BIRTH:__________________________________SOCIAL SECURITY #:______________________________

TO:_______________________________________ADDRESS:____
Name of Doctor or Facility)

CITY:_____________________________STATE:_________PHONE #:________________FAX#:_______________
MUST HAVE THIS NUMBER

I hereby authorize and request you to release and/or disclose the medical information as indicated below to the health care provider I have indicated below. These records are needed for CIRCLE ONE …1.Continuation of care, 2. Change of insurance 3. Change of doctor 4. Second opinion 5. Other____________________________

CALIFORNIA FOOTHILLS MEDICAL ASSOCIATES – DR. ARNOLD I. ROTH
8211 ROCHESTER AVENUE, SUITE 101-PHONE: 909-945-2425
RANCHO CUCAMONGA, CA 91730 – FAX 909-948-6971

DURATION: This authorization shall become effective immediately and shall remain in effect until ___________________(enter date) or will expire one year from the date of signatures.

REVOCATION: This authorization may be revoked in writing by the undersigned at any time prior to the release of information from the disclosing party. Written revocation will not affect any action taken in reliance to this authorization before the written revocation is received.

REDISCLOSURE: I understand that the requester may not lawfully further use or disclose the health information unless another authorization is obtained from me or unless disclosing is specifically required or permitted by law.

SPECIFIY **INITIAL WHICH TYPE OF INFORMATION IS TO BE RELEASED OR DISCLOSED**

______General Medical Information from___________to__________ or if all write in “all”.

______Information regarding specific injury or treatment from_________to _________

______Radiology Reports and _______Laboratory results

______Mental Health (from___________to____________)_________________________ ________
Signature Date

______Alcholol/Drug (from___________to____________) _________________________ ________
Signaure Date

______HIV Testing (from___________to___________) _________________________ _________
Signature Date

Recipient of this information may not re disclose the information, except with written authorization or as specifically required or permitted by law or court order. Health care providers will not condition the provision of care or the receipt of benefits on the signing of this authorization. I have the right to receive a copy of this authorization. The copy is mine to keep. I also have the right to revoke authorization in writing. These records may not be used by recipient for profit by release for any reason, including but not limited to case studies that pay for patient information.

____ _________________

PATIENT SIGNATURE DATE